VA Suicide Prevention

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Suicide Prevention

Brief overview

Suicide in the U.S.

- 13.5 % of all Americans reported a history of suicidal ideation or thinking
- 3.9 % actually made a suicide plan that included a definite time, place and method
- 4.6 % reported actual suicide attempts
- 50 % of those who attempted suicide made a “serious” attempt

Suicide Prevention

Brief overview

Suicide in the veteran population

- Male veterans are twice as likely as civilians of either gender to commit suicide
- 1000 suicides occur per year among veterans receiving VA care
- 5000 suicides occur per year among all living veterans

Suicide Prevention

Brief overview

What do the statistics mean?

- Veterans may be at higher risk for suicide.
- We need to do more to reduce risk.
- Suicides are preventable in most cases.

Basic Model

- Suicide Prevention requires ready access to high quality Mental Health Services, supplemented by programs that address the risk of suicide directly

Enhancing Access to High Quality Care

- Implementation of the MH Strategic plan with support of the Mental Health Initiative
- Enhancing mental health services
  - at community based clinics
  - through integrated care models
- Increased MH coverage in Emergency Departments
- Facilitating transition to VA for returning veterans
- Accelerating access for new patients through new initiatives
- Expansion of recovery/rehabilitation services as keys to hope for patients with serious mental illness
- Disseminating evidence-based psychotherapies

Suicide Prevention

Program approaches

VA National Initiatives

- Research and dissemination of best practices in identification and treatment
- Educating employees at every level
- Partnering with community based organizations and the armed forces
- Veterans Suicide Hotline
- Suicide Prevention Coordinators and Teams
- Enhanced care packages for high risk veterans

Suicide Prevention Coordinators

- Each VA Medical Center has or is in the process of hiring a Suicide Prevention Coordinator (SPC)
- Overall responsibility is to support the identification of high-risk patients and to coordinate ongoing monitoring and enhancements in care.
- Other responsibilities:
  - Promote awareness and community outreach
  - Training – both for provider and Guides
  - "Flagging" patients at high risk
  - Tracking and monitoring high risk patients and their care
  - Participation in patient safety and environmental analysis to develop local suicide prevention strategies

Processes:
Hubs of expertise in suicide prevention

- Provide technical expertise to the field
- Develop training and educational materials and programs for a wide range of providers, staff and community partners
- Conduct research and quickly disseminate findings to the field for implementation
  - VISN 19 MIRECC: Clinical approaches
  - VISN 2 COE: Public Health approaches

Processes: Screening and Triage

- Patient screening for MH conditions is being followed by evaluation of suicide risk in those who screen positive

- Pending requirement for evaluation of new patients within 24 hours of a referral/request for MH services, including evaluation of danger to self or others

Processes:
Tracking and Monitoring

- Development of a template to guide the identification of patients with suicide behaviors, and to ensure monitoring and follow-up
- Development of a national patient alert system so that all providers are aware and are cued to address high-risk patients' needs.
- Monitoring suicide rates to identify national, regional, and local risk factors as well as trends

Enhanced Care for High Risk Patients

When a patient is placed on the high risk the SPC:

•Assures all veterans on the facility high-risk list are being followed closely by their provider to ensure that the veteran's mental health diagnosis and care plan have been reviewed in light of the risk of suicide, and that the care plan appropriately addresses the veteran's conditions and functional limitations

Whenever a veteran is identified as surviving an attempt or is otherwise identified as being at high-risk and placed on the facility high-risk list, the SPC will make personal contact with the veteran and establish a US mail contact program with him or her.

Make recommendations for referrals of repeat attempters to a home tele-health program.

Assure that all of these veterans have a 24-hour resource number to call in the case of an emergency.

Assure that veterans have capacitance if immediate crisis occurs.

Assure that veterans admitted to a hospital as a result of a high-risk for suicide ideation have been placed on high-risk list and are kept on high-risk list for a period of three months after discharge.

Assure that all veterans placed on high-risk list are evaluated weekly for 30 days.

Specific treatments with the potential for reducing suicide risk have been considered. These include clozapine for schizophrenia and lithium for bipolar disorder.

The plan includes ongoing monitoring for suicidality and plans addressing periods of increased risk. These plans must include specific processes of follow-up for missed appointments.

There is an individualized discussion about means restriction that should address issues such as medication storage, gun safety, and high-risk behaviors.

A family member or friend has been identified, either to be involved in care or to be contacted, if necessary.

There is a written safety plan, the plan and the process for developing it are included in the medical record, and the veteran has a copy of the plan.

Operation S.A.V.E.

Developed by:
Education, Training, and Dissemination core of the VISN 2 Center of Excellence
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Suicide Prevention

Myths and Misinformation

- **Myth:** Asking about suicide will plant the idea in a person's head.
- **Reality:** Asking a person about suicide does not create suicidal thoughts any more than asking about chest pain causes angina. The act of asking the question simply gives the person permission to talk about his or her thoughts or feelings.

Suicide Prevention

Myths and Misinformation

- **Myth:** There are talkers and there are doers.
- **Reality:** Most people who die by suicide have communicated some intent. Someone who talks about suicide gives the guide and/or clinician an opportunity to intervene before suicidal behaviors occur.

Suicide Prevention

Myths and Misinformation

- **Myth:** If somebody really wants to die by suicide, there is nothing you can do about it.

- **Reality:** Most suicidal ideas are associated with the presence of underlying treatable disorders. Providing a safe environment for treatment of the underlying cause can save a life. The acute risk for suicide is often time-limited. If you can help the person survive the immediate crisis and overcome the strong intent to die by suicide, you have gone a long way toward promoting a positive outcome.

Suicide Prevention

Myths and Misinformation

- **Myth:** He/she really wouldn't commit suicide because…
  - he just made plans for a vacation
  - she has young children at home
  - he made a verbal or written promise
  - she knows how dearly her family loves her

- **Reality:** The intent to die can override any rational thinking. "No Harm" or "No Suicide" contracts have been shown to be ineffective from a clinical and management perspective. A person experiencing suicidal ideation or intent must be taken seriously and referred to a clinical provider who can further evaluate their condition and provide treatment as appropriate.

Suicide Prevention

Operation S.A.V.E.

The acronym "SAVE" summarizes the steps needed to take an active and valuable role in suicide prevention.

- **S**igns of suicidal thinking
- **A**sk questions
- **V**alidate the person's experience
- **E**ncourage treatment and **E**xpedite getting help

Suicide Prevention

Operation S.A.V.E.

Importance of identification

- Suicidal individuals are not always easy to identify.
- There is no single profile to guide recognition.
- There are a number of warning signs and symptoms.
  - Some of the signs of suicidality are obvious, but others are not.
- Signs and symptoms do not always mean the person is suicidal but:
  - When you recognize signs, it is important to ask the person how they are doing because they may mean that they are in trouble.

Suicide Prevention

Signs of suicidal thinking

Signs and Symptoms:

- Threatening to hurt or kill self
- Looking for ways to kill self
- Seeking access to pills, weapons or other means
- Talking or writing about death, dying or suicide
- Hopelessness
- Rage, anger
- Seeking revenge
- Acting reckless or engaging in risky activities

Suicide Prevention

Signs of suicidal thinking

- Feeling trapped
- Increasing drug or alcohol abuse
- Withdrawing from friends, family and society
- Anxiety, agitation
- Dramatic changes in mood
- No reason for living, no sense of purpose in life
- Difficulty sleeping or sleeping all the time
- Giving away possessions
- Increase or decrease in spirituality

Suicide Prevention

Ask questions

To effectively determine if a person is suicidal, one needs to interact in a manner that communicates concern and understanding. As well, one needs to know how to manage personal discomfort(i.e., anxiety, fear, frustration, personal, cultural or religious values) in order to directly address the issue.

Know how to ask the most important question

The most difficult **S. A. V. E.** step is asking the most important question of all –

"Are you thinking of killing yourself."

Suicide Prevention

Ask questions

How DO I ask the question?

- DO ask the question after you have enough information to reasonably believe the person is suicidal.
- DO ask the question in such a way that is natural and flows with the conversation.

DON'T ask the question as though you are looking for a "no" answer. "You aren't thinking of killing yourself are you?"

Suicide Prevention

Ask questions

Things to consider when you talk with the person:

Remain calm
Listen more than you speak
Maintain eye contact
Act with confidence
Do not argue
Use open body language
Limit questions to gathering information casually
Use supportive and encouraging comments
Be as honest and "up front" as possible

Suicide Prevention

Validate the veteran's experience

Validation means:

- Show the person that you are following what they are saying
- Accept their situation for what it is
- You are not passing judgment
- Let them know that their situation is serious and deserving of attention
- Acknowledge their feelings
- Let him or her know you are there to help

Suicide Prevention

Encourage treatment and Expedite getting help

For the cooperative person:

Tips for encouraging treatment:

1. Explain that there are trained professionals available to help them.
2. Explain that treatment works.
3. Explain that getting help for this kind of problem is no different than seeing a specialist for other medical problems.
4. Tell them that getting treatment is his or her right.
5. If they tell you that they have had treatment before and it has not worked, try asking: "What if this is the time it does work?"

Suicide Prevention

Encourage treatment and Expedite getting help

Tips for expediting a referral:

1. Assist the person in getting to a care facility by personally taking them or arranging for transportation.
2. Call the VA Suicide Hotline number with the veteran to get a referral started. 1-800-273-TALK – push "1".
3. Call the local facility Suicide Prevention Coordinator – you make access this person from the information desk at any VA.

Suicide Prevention

Encourage treatment and Expedite getting help

For uncooperative people or those in immediate crisis:

As you encourage the person to seek help, some situations may involve people who are hostile and aggressive.

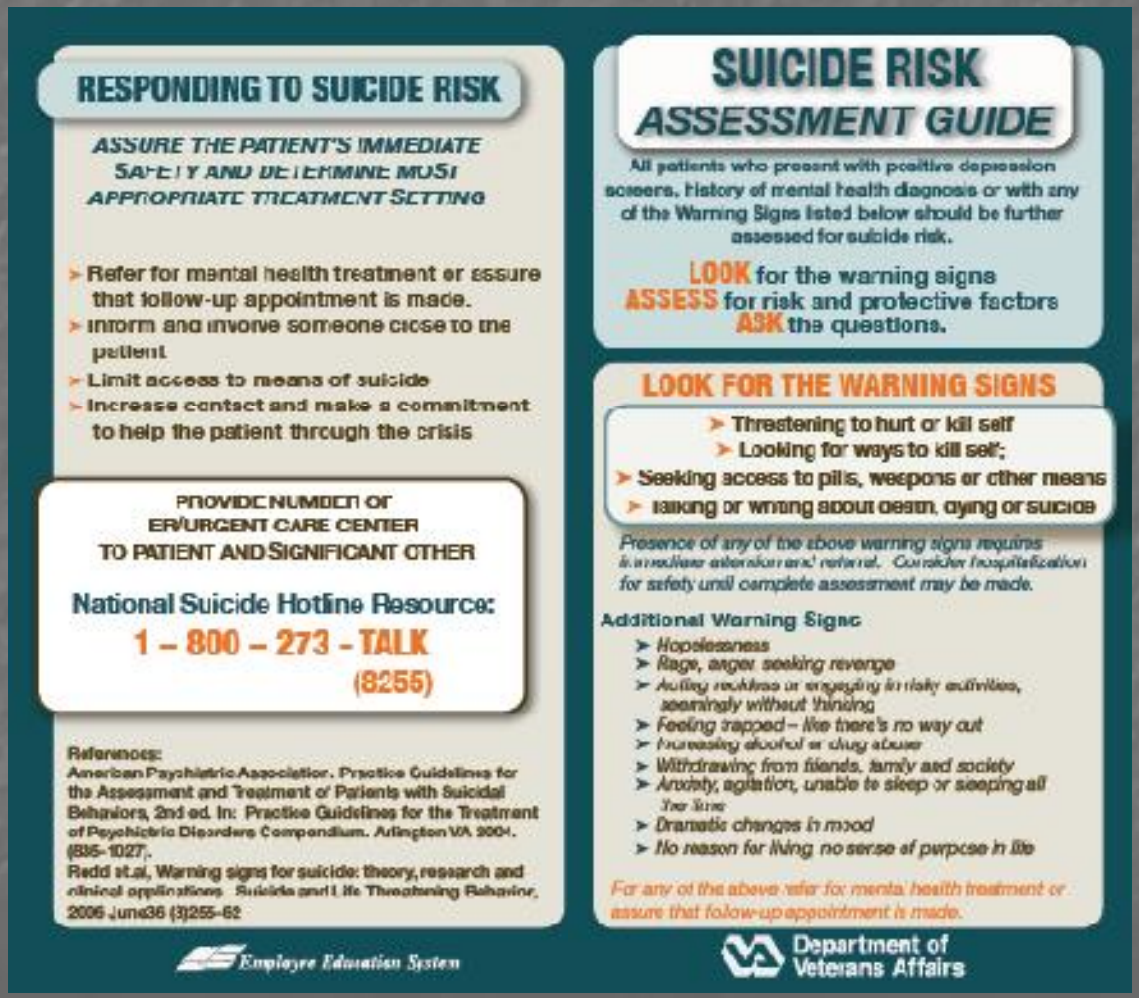
Here are some useful safety guidelines for working with seriously and acutely distressed people:

[These rules are both for the person's safety and yours.]

- If you are not in face-to-face contact but are speaking over the phone with a person who expresses intent to harm self or others - **call 911 for assistance.**

Suicide risk assessment

A process – not an event…


RESPONDING TO SUICIDE RISK
ASSURE THE PATIENT'S IMMEDIATE SAFETY AND DETERMINE MOST APPROPRIATE TREATMENT SETTING
Refer for mental health treatment or assure that follow-up appointment is made.
Inform and involve someone close to the patient
Limit access to means of suicide
Increase contact and make a commitment to help the patient through the crisis
PROVIDE NUMBER OF EMERGENT CARE CENTER TO PATIENT AND SIGNIFICANT OTHER
National Suicide Hotline Resource:
1 – 800 – 273 - TALK
(8255)
References:
American Psychiatric Association. Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, 2nd ed. In: Practice Guidelines for the Treatment of Psychiatric Disorders Compendium. Arlington VA 2004. (835-1027).
Redd et.al, Warning signs for suicide: theory, research and clinical applications. Suicide and Life Threatening Behavior. 2006 June36 (3)255-62
Employee Education System
SUICIDE RISK
ASSESSMENT GUIDE
All patients who present with positive depression screens, history of mental health diagnosis or with any of the Warning Signs listed below should be further assessed for suicide risk.
LOOK for the warning signs
ASSESS for risk and protective factors
ASK the questions.
LOOK FOR THE WARNING SIGNS
Threatening to hurt or kill self
Looking for ways to kill self;
Seeking access to pills, weapons or other means
Talking or writing about death, dying or suicide
Presence of any of the above warning signs requires immediate attention and referral. Consider hospitalization for safety until complete assessment may be made.
Additional Warning Signs
Hopelessness
Rage, anger seeking revenge
Acting reckless or engaging in risky activities, seemingly without thinking
Feeling trapped – like there's no way out
Increasing alcohol or drug abuse
Withdrawing from friends, family and society
Anxiety, agitation, unable to sleep or sleeping all the time
Dramatic changes in mood
No reason for living, no sense of purpose in life
For any of the above refer for mental health treatment or assure that follow-up appointment is made.
Department of Veterans Affairs

A number of psychosocial factors are also associated with risk for suicide and suicide attempts. These include recent life events such as losses (esp. employment, careers, finances, housing, marital relationships, physical health, and a sense of a future), and chronic or long-term problems such as relationship difficulties, unemployment, and problems with the legal authorities (legal charges).

Psychological states of acute or extreme distress (especially humiliation, despair, guilt and shame) are often present in association with suicidal ideation, planning and attempts. While not uniformly predictive of suicidal ideation and behavior, they are warning signs of psychological vulnerability and indicate a need for mental health evaluation to minimize immediate discomfort and to evaluate suicide risk.

LOOK FOR THE WARNING SIGNS

What are warning signs and why are they important?

There are a number of known suicide risk factors. Nevertheless, these risk factors are not necessarily closely related in time to the onset of suicidal behaviors – nor does any risk factor alone increase or decrease risk. Population-based research suggests that the risk for suicide increases with an increase in the number of risk factors present, such that when more risk factors are present at any one time the more likely that they indicate an increased risk for suicidal behaviors at that time.

A recent review of the world's literature has identified a number of warning signs that empirically have been shown to be temporally related to the acute onset of suicidal behaviors (e.g., within hours to a few days). These signs should warn the clinician of ACUTE risk for the expression of suicidal behaviors, especially in those individuals with other risk factors (Rudd, et al., 2006). Three of these warning signs (bolded on the **VA SUICIDE RISK ASSESSMENT** Pocket Card) carry the highest likelihood of short-term onset of suicidal behaviors and require immediate attention, evaluation, referral, or consideration of hospitalization.

THE FIRST THREE WARNING SIGNS ARE:

Threatening to hurt or kill self

Looking for ways to kill self; seeking access to pills, weapons or other means

Talking or writing about death, dying or suicide

The remaining list of warning signs should alert the clinician that a mental health evaluation needs to be conducted in the **VERY** near future and that precautions need to be put into place **IMMEDIATELY** to ensure the safety, stability and security of the individual.

Hopelessness

Rage, anger, seeking revenge

Acting reckless or engaging in risky activities, seemingly without thinking

Feeling trapped – like there's no way out

Increasing alcohol or drug abuse

Withdrawing from friends, family or society

Anxiety, agitation, unable to sleep or sleeping all the time

Dramatic changes in mood

No reason for living, no sense of purpose in life

Other behaviors that may be associated with increased short-term risk for suicide are when the patient makes arrangements to divest responsibility for dependent others (children, pets, elders), or making other preparations such as updating wills, making financial arrangements for paying bills, saying goodbye to loved ones, etc.

SPECIFIC FACTORS THAT MAY INCREASE OR DECREASE RISK FOR SUICIDE

Risk and protective factors:

Factors that may increase risk or factors that may decrease risk are those that have been found to be statistically related to the presence or absence of suicidal behaviors. They do not necessarily impart a causal relationship. Rather they serve as guidelines for the clinician to weigh the relative risk of an individual engaging in suicidal behaviors within the context of the current clinical presentation and psychosocial setting. Individuals differ in the degree to which risk and protective factors affect their propensity for engaging in suicidal behaviors. Within an individual, the contribution of each risk and protective factor to their suicidality will vary over the course of their lives.

Factors that may increase a person's risk for suicide include:

Current ideation, intent, plan, access to means
Previous suicide attempt or attempts
Alcohol / Substance abuse
Current or previous history of psychiatric diagnosis
Impulsivity and poor self control
Hopelessness – presence, duration, severity
Recent losses – physical, financial, personal
Recent discharge from an inpatient psychiatric unit
Family history of suicide
History of abuse (physical, sexual or emotional)
Co-morbid health problems, especially a newly diagnosed problem or worsening symptoms
Age, gender, race (elderly or young adult, unmarried, white, male, living alone)
Same- sex sexual orientation

Factors that may decrease the risk for suicide are also called protective factors.
These include:

Positive social support
Spirituality
Sense of responsibility to family
Children in the home, pregnancy
Life satisfaction
Reality testing ability
Positive coping skills
Positive problem-solving skills
Positive therapeutic relationship

Are you feeling hopeless about the present or future?

If yes ask…..

Have you had thoughts about taking your life?

If yes ask….

When did you have these thoughts and do you have a plan to take your life?

Have you ever had a suicide attempt?

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Veteran Suicide Hotline

- In conjunction with the national suicide prevention hotline number 1-800-273-TALK.
- VA option will direct Veterans to a VA professional who will immediately address their crisis situation.
- Hand-off to local Suicide Prevention Coordinators for follow-up and assurance that these veterans in crisis receive on-going care
- Use of hotline calls to
  - engage veterans in MH care,
  - trigger intensifying care
  - allow program-solving about difficulties in care

The VA "Hotline" is different…

- Staffed with all VA mental health professionals
- Ability to access enrolled patients Medical Records
- Ability to provide on the phone counseling and immediate referral services
- Ability to "follow-up" to assure referral was received and care provided.

Hotline Work Flow

Calls come into the Hotline:

↓

Mental Health Professional responds to incoming call and conducts phone interview

↓

Assesses emotional, functional, and/or psychological conditions

↓

Assesses if the call is:

Emergent – requires emergency services to keep caller safe
Urgent – requires same day services at local VA
Routine – SPC consult sent
Informational only – talk and information given

VA National Suicide Prevention Hotline Call Report -Totals (June 09)

Total calls	162,475
Identified as Veterans	78,098
Identified as family / friend	10,089
SPC referral	16,135
Rescues	4,343
Warm transfers	6,450
Active Duty	1,918

Hotline Referral Outcomes (FY09 to date only)

Admissions	1375
Enrolled	238
Referrals to other services	8890
Immediate evaluations	424

Other aspects

- Warm transfers
  - RN Call Centers
  - Research Studies
  - Community Crisis Lines
  - VA call centers

Other aspects cont.

- "Help Center"
  - Central Office
  - Business Office
  - Congressional Liaison Offices

Other Aspects cont.

- VA e-mail help desk
- Lifeline / Knowledge Bank Web site

Call "triggers"

Relationship and family issues

Financial concerns

Fear of homelessness or poor current living situations

Sleep issues

Pain

Etc…

And by the way…

- PTSD
- History of abuse
- Mental Illness
- Substance and Alcohol Use

Growing concerns

- Ability to meet our newest veterans access needs
- Increasing internet use for information and services
- Access

Future Developments

One – to – One Chat Line capabilities

- establish trust
- provide support
- refer to hotline in crisis situations
- increase access

Summary of SPC Reports and Suicides and Attempts

Oct 2008-Mar 2009

Overall Findings on Survivors

10/08 until 3/09

	Count	%
Total reports	5299	
Unique survivors	4324	
With 1 or more repeats	347	8.02%
Subsequent suicide	20	0.46%

Average follow-up ~ 3 months


IT
TAKES
THE
COURAGE AND STRENGTH
OF A WARRIOR
TO ASK FOR HELP.....
If you're in an emotional crisis
call 1-800-273-TALK "Press 1 for Veterans"
www.suicidepreventionlifeline.org
NATIONAL SUICIDE PREVENTION LIFELINE
Department of Veterans Affairs